STATEMENT OF
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THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE DEPARTMENT OF VETERANS AFFAIRS
FY 2006 BUDGET REQUEST

FEBRUARY 16, 2005

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to present The American Legion's views on the Department of Veterans Affairs' (VA's) fiscal year 2006 budget request. The American Legion continues to advocate for adequate funding levels to ensure America's veterans receive the health care and benefits they have earned through their honorable service to this country. With young servicemembers currently deployed to more than 130 countries, it is the responsibility of this Committee to ensure VA is indeed capable of meeting its obligation to provide for America's veterans. The American Legion commends the Committee for holding this hearing to discuss this important matter.

Mr. Chairman, the quality of care provided through the VA Health Care System has improved considerably in the past few decades. VA has recognized the need to treat the nation's veterans with the highest quality of care possible and today VA hospitals are consistently recognized as the top providers of health care in America.

Although the quality of VA health care has improved, the current problem facing today's veterans who are turning to VA for their health care needs is inaccessibility. In recent years, veterans have experienced incredibly long wait times at VA health care facilities. In early 2003, the backlog of veterans waiting to be seen at VA health care facilities reached 300,000. The American Legion responded to this health care crisis by implementing the "I Am Not A Number" campaign that identified veterans who were dealing with long wait times, cancelled appointments and long commutes to VA facilities. It was our intention to remind VA that patients of the VA health care system are individual veterans deserving of care and not simply numbers on a list.

As a result of the "I Am Not A Number" campaign, leadership and staff of The American Legion visited VA health care facilities nationwide to meet with VA Administration and gain a better perspective of the challenges faced by VA in providing timely access to health care. The American Legion is continuing those visits and will have visited all VA hospitals within the continental United States by June 2005. National Commander Tom Cadmus will be issuing the third in a series of Reports on the Condition of VA Health Care in America that reflect the findings of the visits later this year.

It is important that VA be funded at a level that will allow it to improve accessibility not only to the current population of veterans but to those service members who are currently serving to protect the freedoms of this nation. In light of this demand, The American Legion recommends the following discretionary funding levels for fiscal year 2006.

BUDGET PROPOSALS FOR SELECTED DISCRETIONARY PROGRAMS FOR DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 2006

Program	VA FY 2005[1] Appropriation	VA FY 2006 Request	Legion's FY 2006 Request
Medical Care ***Including:***	$30 billion	$31 billion	$34.1 billion (includes MCCF)
• *Medical Services*	*$19 billion*	*$22 billion*	
• *Medical Administration*	*$4.6 billion*	*$4.4 billion*	
• *Medical Facilities*	*$3.7 billion*	*$3.9 billion*	
• *Medical Care Collections*	*$2 billion (Offset)*	*$2.6 billion (Offset)*	*$2.6 billion (Supplement)*[2]
• *DoD/VA HCIF*		*$15 million*	
Medical & Prosthetics Research	$393 million	$365 million	$447 million
Construction	$578 million	$750 million	$ 1.6 billion
• Major	*$442 million*	*$590 million*	*$327 million*
• CARES *(dedicated)*	*($341 million)*		*($1 billion Major and Minor)*
• Minor	*$212.3 million*	*$ 160 million*	*$261 million*
• CARES *(dedicated)*	*($167million)*		
State Extended Care Facilities	$104.3 million	MORATORIUM	$124 million
State Veterans' Cemeteries	$32 million	$32 million	$42 million
NCA	$273 million	$290 million	$274 million
Departmental Management	$1.3 billion	$1.1 billion	$1.8 billion

[1] Includes 0.8% rescission.
[2] Third-party reimbursements should supplement rather than offset discretionary funding.

Once again, Congress has been given a proposed budget for VA that includes provisions that would place more of the burden of payment on the veteran. The FY 2006 proposed VA Budget would require a $250 annual enrollment fee for Priority Groups 7 and 8 veterans. Under this budget proposal, two groups of eligible veterans would now be required to pay an annual fee to access the very health care system that was created to treat their unique needs. Those Category 8 veterans who escaped the shut out in 2003 and are currently enrolled in VA would now find themselves paying out of pocket to be treated at VA.

The FY 2006 Proposed VA Budget would also raise the pharmaceutical co-payment for Priority Groups 7 and 8 veterans to more than twice the current rate.

While The American Legion understands all too well the funding crisis within VA, the solution to this problem is not to balance the VA budget on the backs of America's veterans. The solution is to provide guaranteed funding for VA.

As a nation at war, The American Legion advocates increasing VA funding in FY 2006 to meet the increased health care demand of America's veterans. In response to the overwhelming backlog of veterans seeking care at VA, former VA Secretary, Anthony Principi was forced to prohibit enrollment of new Priority Group 8 veterans. Many of the recently separated service members, especially Reservists and National Guard personnel, will qualify as Priority Group 8 veterans and will be denied enrollment, unless they served in theaters of operation. However, this new demand for services places even greater demands on VA to provide timely access to quality medical care.

MEDICAL CARE

Today, there are nearly 25 million veterans. As more choose to use VA as their primary health care provider (over 8 million veterans enrolled or waiting to enroll), the strain on the system continues to grow. The American Legion fully supported the enactment of Public Law 104-262, the Veteran's Healthcare Eligibility Reform Act that opened enrollment in the VA health care system. Many veterans who, until this time, were ineligible for VA health care were now able to enroll. Veterans recognize that VHA provides affordable, quality care that they cannot receive anywhere else.

The astronomical growth of Priority Groups 7 and 8 veterans seeking health care at their local VA medical facility resulted in over 300,000 veterans being placed on waiting lists regardless of their assigned Priority Group. FY 2003 saw the suspension of enrollment of new Priority Group 8 veterans due to this growth in enrollees. The American Legion does not agree with the decision to deny health care to veterans simply to ease the backlog. Denying earned benefits to eligible veterans does not solve the problems resulting from an inadequate budget.

Additionally, VA must be capable of providing health care to the new era of veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom. These young servicemembers have earned the right to health care through VA and we as a nation must ensure that that right is protected by fully funding VA. According to VA as of January 2005, 48,733 veterans of Operation Iraqi Freedom have presented themselves to VA for medical care. The cost of treating these veterans, and all enrolled veterans, is a continuing cost of war that cannot be ignored.

The American Legion recommends $34.1 billion for Medical Care in FY 2006.

MEDICARE REIMBURSEMENT

Under current law, VA is required to seek third-party reimbursements for the treatment of enrolled veterans' nonservice-connected medical conditions. Upon enrollment, veterans are asked to provide information on their health care insurance coverage. Over half of the enrolled VA patient population lists the Centers for Medicare and Medicaid Services (CMS). However, current law prohibits VA from collecting from CMS for the treatment of enrolled Medicare-eligible veterans.

The American Legion recommends Congress authorize VA to collect third-party reimbursements from the Centers for Medicare and Medicaid Services.

MEDICAL CARE COLLECTION FUND

Public Law 105-33, the Balanced Budget Act of 1997, established the Department of Veterans Affairs (VA) Medical Care Collections Fund (MCCF) and requires that amounts collected or recovered after June 30, 1997, be deposited into this fund. The MCCF is a depository for funds collected from third party insurance, outpatient prescription co-payments and other medical charges and user fees. The funds collected may only be used for providing VA medical care and services and for VA expenses for identification, billing, auditing and collection of amounts owed the Government.

Funds collected through MCCF are also used as an offset rather than as a supplement to appropriations for the medical care budget. The efficient and timely collection of these reimbursable costs would greatly benefit the VHA in helping meet the demands for a severely impacted veteran's health care system. The American Legion adamantly opposes offsetting annual VA discretionary funding by the MCCF recovery. By off-setting these funds the VA loses valuable funding that is not representative of the veteran population in VERA allocations (Priority Groups 7 and 8) nor does it allow for the full utility of collecting from Medicare, the largest health insurance provider.

Technically, the MCCF is not considered a Treasury offset because the funds collected do not actually go back to the MCCF treasury account, but remain within VHA and are used for operating funds. Instead, in developing a budget proposal, it appears that the total appropriation request is reduced by the estimate for MCCF for the fiscal year in question. We fail to see the difference in the net effect to the VISNs and VAMCs.

The American Legion opposes reducing annual VA discretionary funding by the MCCF recovery estimate.

MANDATORY FUNDING OF VA MEDICAL CARE

The simple fact is that the Veterans Health Administration (VHA) does not have the funding needed to treat all veterans seeking care from VA. VHA operates under a constant cloud of fiscal uncertainty. Over the last several years, VHA has struggled to meet the increased demand

for care while staying within budget constraints. These budgetary uncertainties create problems within VA's health care system. Future spending projections, staffing levels, equipment purchases, structural improvements are all stalled if the funding is not a certainty.

In an effort to provide a stable and adequate funding process, The American Legion has joined with Nine other Veterans Service Organizations in support of mandatory funding for veterans' medical care.

The American Legion and the Partnership of veterans' service organizations adamantly believe VA Medical Care should receive annual guaranteed appropriations to meet the health care needs of VA's enrolled patient population. The adverse impact of continued inadequate discretionary funding on VA's ability to provide timely access to quality health care is well documented. The President's Task Force to Improve Health Care Delivery for our Nation's Veterans advanced two proposals – one advocates re-designation of VA medical care as mandatory funding (like Medicare or Social Security), rather than discretionary funding; the other recommends creation of an independent board to recommend the VA medical care annual funding needs.

The American Legion supports guaranteed funding of the VA health care delivery system.

G.I. BILL OF HEALTH

Over a decade ago, The American Legion offered its blueprint for VA in the 21st Century called the G.I. Bill of Health. The vision was to create a national integrated veterans' health care network accessible by all veterans and their dependents, including military retirees and their eligible family members. This bold plan called for Congress, beneficiaries, and third-party insurance providers to meet their respective fiscal obligations.

The first step called for enrollment of all beneficiaries seeking enrollment in the Veterans Health Administration (VHA). Enrollment would provide the VA Secretary with a quantified and defined patient population. Once enrolled, each beneficiary would identify how his or her health care coverage would be paid. If a beneficiary was eligible for full health care coverage paid for by just the Federal government (Medicare-eligible, 100 percent service-connected disabled veteran or military retiree), Congress would appropriate funds to cover that cost. However, if the beneficiary was eligible for full health care coverage paid by several Federal agencies (a Medicare-eligible, 100 percent service-connected disabled veteran, and a military retiree), Congress would make only one payment; however, the beneficiary would seek health care only within the VHA unless referred to the private sector for care. Medicare-eligible veterans choosing this option would be authorized to seek health care only from within VHA medical facilities (VA Advantage model).

Third-Party Reimbursements Contribute to the Costs

Those beneficiaries choosing to enroll, with private or public health benefit coverage, would identify their third-party insurance provider and would agree to meet all co-payments and deductibles described by their policy. Should the third-party insurer refuse to make reimbursements to VA for the treatment of nonservice-connected medical conditions, the beneficiary would be denied enrollment.

Uninsured Beneficiaries have Affordable Options

For those beneficiaries choosing to enroll with no health benefit coverage, VA would be authorized to offer affordable health benefit packages to meet their individual health care needs. The Secretary would establish the premiums for each health benefit package and could waive premiums on a case-by-case basis.

For those beneficiaries identified in title 38, United States Code, (USC) for the VA Secretary to provide care, Congress would appropriate funds to cover the cost of the required health benefit coverage necessary, based on their individual health care needs. For those beneficiaries identified by the DoD Secretary to receive care, Congress would appropriate funds to cover the cost of the required health benefit coverage necessary, based on their individual health care needs. For those Medicare-eligible beneficiaries, Congress would appropriate funds to cover the cost of the required health benefit coverage necessary, based on their individual health care needs. All other beneficiaries would be responsible for meeting their health care needs through co-payments, deductibles, premiums, or third-party reimbursements from public or private insurance providers. All revenue streams (Federal appropriations, co-payments, deductibles, premiums, and third-party reimbursements) would go to a Veterans Health Trust Fund, similar to the Social Security and Medicare Trust Funds.

The American Legion believes these are solid recommendations for improvement of VHA.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES) AND MEDICAL CONSTRUCTION

MAJOR CONSTRUCTION UNDER CARES

Over the past four years, The American Legion has carefully followed the progress of the Secretary of Veterans Affairs' Capital Asset Realignment for Enhanced Services (CARES) process. CARES has been an incredibly complex national process to reorganize VA through a data driven assessment of veterans' health care needs through the years 2012 and 2022. CARES is the future of VA health care delivery of services that will, ostensibly, meet veterans' current and future health care needs. The American Legion has participated at each stage of the process by gathering information on VA Medical Centers throughout the country to make certain medical facilities were not closed simply to save money.

In May 2004, then Secretary Principi released his final CARES decisions and the implementation process is going forward. While The American Legion was not in total agreement with all the decisions made so far, we feel the process was fair due in large part to the hard work and input of The American Legion leadership, membership and national staff and that of numerous other stakeholders. As the implementation process continues, The American Legion is prepared to remain vigilant to assure that veterans are not deprived of their earned health care.

The CARES decision supports establishing new hospitals in three locations - Orlando, Las Vegas, and Denver. It also supports new bed towers in Tampa and San Juan, 156 new community clinics in 33 states and territories, a new multi-specialty outpatient clinic in Columbus, four new or expanded spinal cord injury centers and two new blind rehabilitation

centers. Included in the plan are the closures of the Highland Drive (PA), Brecksville (OH) and Gulfport (MS) facilities.

The American Legion believes VA should exercise caution during the planning phases for these closures. No doors should be closed for services before new services are in place and functioning. Contingency planning needs to take place and stakeholders should be involved in all aspects of the implementation of these closures. Through the CARES process over one hundred major construction projects were identified and submitted for review. VA prioritized these major capital investments through FY 2010. A plan of this magnitude requires a significant amount of resources to include trained and experienced personnel. This will have a major impact on VA's ability to move forward with the construction projects, even if they have the needed funding.

To successfully implement the CARES decision, VA has estimated that it will require an infusion of a $1 billion per year for the next six years, with continuing substantial infrastructure investments well into the future. The American Legion is opposed to the CARES funding coming out of the discretionary medical care account. The American Legion believes the CARES implementation must occur in the context of a fully utilized VA health care system. It must take into consideration VA's role in emergency preparedness, organizational capacity for "special emphasis programs" like mental health, long-term care, domiciliary and homeland security. Further, there must be continued oversight of the integration of the CARES process into the strategic planning process.

CARES IMPLEMENTATION

Of the amount appropriated for medical care in fiscal year 2005, P. L. 108-477 authorizes the Secretary of Veterans Affairs (Secretary) to divert $400,000,000 for the implementation of CARES under the Major Construction account. The American Legion strongly opposes the use of needed medical care funding for the implementation of CARES.

The American Legion recommends $1.58 billion for Major Construction in FY 2006, including $1 billion for CARES.

The American Legion supports a separate appropriation of $1 billion per year for the next 6 six fiscal years for the implementation of CARES.

MINOR CONSTRUCTION

Similar to VA's major construction program, VA's minor construction program has likewise suffered significant neglect over the past several years. The requirement to maintain the infrastructure of VA's buildings is no small task. When combined with the added cost of the CARES program recommendations and the request for minor infrastructure upgrades in several research facilities, it is easy to see that a major increase over the previous funding level of $211 million is crucial.

The American Legion recommends $ 261 million for Minor Construction in FY 2006.

MEDICAL AND PROSTHETICS RESEARCH

VA's Medical and Prosthetic Research Service has a history of productivity in advancing medical knowledge and improving health care not only for veterans, but for all Americans. VA research has led to the creation of the cardiac pacemaker, nicotine patch, and the Computerized Axial Tomography (CAT) scan, as well as other medical breakthroughs. Over 3800 VA physicians and scientists conduct more than 9,000 research projects each year involving more than 150,000 research subjects.

The VA Medical and Prosthetic Research budget has not kept pace with inflation during the past 15 years. It is essential that Congress and the Administration support strong medical and prosthetic research programs within VA so that veterans and all citizens continue to benefit from the exceptional research capability of the Department.

The American Legion supports adequate funding for VA biomedical research activities. Congress and the Administration should encourage acceleration in the development and initiation of needed research on conditions that significantly affect veterans - such as prostate cancer, addictive disorders, trauma and wound healing, post-traumatic stress disorder, rehabilitation, and others - jointly with the Department of Defense (DoD), the National Institutes of Health (NIH), other Federal agencies, academic institutions.

The American Legion recommends $ 447 million for Medical & Prosthetics Research in FY 2006.

LONG TERM CARE

This year, VA adds three new legislative initiatives toward minimizing its financial responsibility to America's aging veterans.

ELIMINATE VA NURSING HOME CARE UNITS MANDATORY CENSUS REQUIREMENTS UNDER 38 U.S.C. § 1710B(b).

The Veterans Millennium Health Care and Benefits Act of 1999, P. L. 106-117, 113 Stat. 1545 (1999), (Millennium Act) (codified at 38 U.S.C. § 1710B(b)), requires VA to maintain its in-house Nursing Home Care Unit (NHCU) bed capacity at the 1998 level of 13,391. The American Legion does not believe this requirement of law constitutes a "baseline for comparison"; rather we maintain that the language in the law is quite clear.

> (b) The Secretary shall ensure that the staffing and level of extended care services provided by the Secretary nationally in facilities of the Department during any fiscal year is not less than the staffing and level of such services provided nationally in facilities of the Department during fiscal year 1998.

This capacity has significantly eroded rather than maintained. In 1999 there were 12,653 VA NHCU beds, 11,812 in 2000, 11,672 in 2001 and 11,969 in 2002. VA estimates it will have only 9795 beds in fiscal year 2006.

This issue has a contentious recent history.

It was charged in the House Veteran's Affairs Committee's (HVAC) FY 2004 Budget *Views and Estimates* that VA plans to do away with a large part of its existing LTC beds, to wit:

> The Committee has been in regular communication with the Secretary concerning a noted decline in VA nursing home beds (approximately 2,000 beds). On May 8, 2002 the Secretary made a commitment to restore these beds to their prior level, provided that Congress appropriates an increase in VA's medical care appropriation for fiscal year 2003. In the omnibus appropriation approved by Congress on February 13, 2003, VA received $1.1 billion more than what was requested by the President for the period.
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> The Committee is disappointed by the Secretary's proposal in this budget to close thousands of additional VA nursing home beds. VA's own long-term care model, based on the medical needs of its users, indicated a need for 17,000 new nursing home beds by 2020. The Committee does not believe that VA can replace 5,000 nursing home beds with outpatient programs for elderly, chronically ill veterans.
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> VA has never fulfilled the promise of its landmark mid-1980's study, *Caring for the Older Veteran*. That study recommended large increases in both inpatient and alternative programs, such as respite, hospice, adult-day and home-based care, so that VA could approach the needs of World War II veterans with meaningful, health and end-of-life care programs, on both institutional and noninstitutional bases. This has not been achieved.
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> In order to aid the Department in maintaining its current nursing home bed level, the Committee recommends that VA's budget request be augmented by an additional $297 million. Furthermore, VA should fund effective alternatives to long-term care and reopen long-term care nursing beds that have been closed.

VA has claimed that it cannot maintain both the mandated bed capacity and implement all the non-institutional programs required by the Millennium Act. In a February 2002 letter to HVAC Ranking Democratic Member Lane Evans, Secretary of Veterans Affairs Anthony Principi stated:

> "I have come to the conclusion that as long as we continue to use VA inpatient average daily census (ADC) as the singular measure for long-term care capacity, it will not be possible for VA to meet the requirements of P.L. 106-117 without adversely affecting our ability to provide other essential health care services to veterans on a timely basis."

On March 20, 2002, the Secretary forwarded a plan to HVAC to restore VA NHCU bed capacity to the 1998 level including "substantial implications" for doing so. The cost was to be offset by forgoing planned expansion of contract community nursing care, decreasing education and research programs, reprogramming technology infrastructure requirements, transferring a portion of the SVH construction budget and converting intermediate medicine beds to NHCU beds. Following these "threats", HVAC replied on March 26 that it was prepared to recommend appropriation of additional funds to enable VA to comply with the law.

VA has made clear its determination not to expand it's own Nursing Home Care Unit bed capacity; in fact, VA has defied Congress' mandate to maintain its 1998 bed capacity of 13,391. Instead VA's inpatient nursing home bed count now stands at 9795.

The American Legion supports the maintenance of VA Nursing Home Care Unit bed capacity at the 1998 level of 13,391.

STATE VETERANS HOMES PER DIEM

VA's Budget Request for fiscal year 2006 contains a legislative proposal that would restrict eligibility for State Veterans Homes (SVH) Per Diem payments for long term (maintenance) care to veterans in Priority Groups 1 through 3 and catastrophically disabled Priority Group 4 veterans. Non-catastrophically disabled Priority Group 4 and Priority Groups 5 through 8 would be entitled to only short-term care. This is unacceptable to The American Legion.

The State Veteran Homes have been a successful cost-sharing program between VA, the States and the veteran. Veterans in SVHs tend to be without family, indigent and requiring of Aid and Attendance. One SVH has estimated that these eligibility criteria would cut its Average Daily Census by over 50 percent and cost the facility $2 million per year. This proposal would spell financial disaster for SVHs and would result in a new population of homeless elderly veterans on our streets, especially in states with poor Medicaid nursing home reimbursement rates. It has also been suggested that a surge in claims for service connection would ensue as SVHs scramble to qualify veterans for inclusion in Priority Groups 1 through 3 and catastrophically disabled Priority Group 4.

The American Legion supports increasing the amount of authorized per diem payments to 50 percent of the cost of nursing home and domiciliary care provided to veterans in State Veterans Homes and full reimbursement for veterans with 70 percent or greater service-connected disabilities. The American Legion also supports the provision of prescription drugs and over-the-counter medications to veterans with 50 percent or greater service-connected disabilities, along with the payment of authorized per diem to State Veterans Homes. The National Association of State Veterans Homes and VA should develop mutual planning efforts, enhanced medical sharing agreements, and enhanced-use construction contracts with qualified providers.

The American Legion opposes any legislative changes in the eligibility criteria for receipt of State Veterans Homes Per Diem.

STATE EXTENDED CARE FACILITY GRANTS PROGRAM

The fiscal year 2006 VA Budget Request contains zero dollars for the State Extended Care Facility Grants Program; instead VA would impose a one-year "moratorium" on grants for new facilities construction while VA completes a nationwide infrastructure assessment study of its institutional long term care. The American Legion agrees that such a study is long overdue; projections for long-term care inpatient capacity were largely left out of the CARES process. We fail to see the utility in suspending payment of construction grants in FY 2006, especially in states having never previously applied and in states having significant need.

State Veterans Homes were founded for indigent and disabled Civil War veterans beginning in the late 1800s and have continued to serve subsequent generations of veterans for over one hundred years. Under the provisions of 38 USC, VA is authorized to make payments to states to assist in the construction and maintenance of State Veterans Homes. Today, there are 109 State Veterans Homes facilities in 47 states with over 23,000 beds providing nursing home, hospital, and domiciliary care. The State Veterans Home Program has proven to be a cost-effective provider of quality care to many of the nation's veterans and this program is an important adjunct to VA's own nursing, hospital, and domiciliary programs. The Grants for Construction of State Extended Care Facilities provides funding for 65 percent of the total cost of building new veterans homes. VA has not been able to keep pace with the number of grant applications; currently there is over $120 million in unfunded new construction projects pending.

Recognizing the growing long-term health care needs of older veterans, it is essential that the State Veterans Home Program be maintained as a viable and important alternative health care provider to the VA system.

The American Legion recommends $124 million for the State Extended Care Facility Grants Program in FY 2006.

NATIONAL CEMETERY ADMINISTRATION (NCA)

THE NATIONAL CEMETERY SYSTEM

VA's National Cemetery Administration (NCA) is comprised of 120 cemeteries in 39 states and Puerto Rico as well as 33 soldiers' lots and monuments. NCA was established by Congress and approved by President Abraham Lincoln in 1862 to provide for the proper burial and registration of graves of Civil War dead. Since 1973, annual interments in NCA have increased from 36,400 to over 84,800. Annual burials are expected to increase to more than 115,000 in the year 2010 as the veteran population ages. Currently 59 national cemeteries are closed for casket burials. Most of these can accept cremation burials, however, and all of them can inter the spouse or eligible children of a family member already buried. Another 22 national cemeteries are expected to close by the year 2005, but efforts are underway to forestall some of these closures by acquiring adjacent properties.

Congress must provide sufficient major construction appropriations to permit NCA to accomplish its stated goal of ensuring that burial in a national or state cemetery is a realistic option by locating cemeteries within 75 miles of 90 percent of eligible veterans.

P.L. 107-117 required NCA to build six new National Cemeteries. Fort Sill opened in 2001 under the fast-track program, while the remaining five, Atlanta, Detroit, South Florida, Pittsburgh and Sacramento are in various stages of completion. Additional acreage is currently under development in 10 national cemeteries, columbaria are being installed in 4 and additional land for gravesite development has been acquired at national cemeteries in 5 states. 9 national cemeteries are expected to close to new interments between 2005 and 2010. The rate of interments in national cemeteries has increased from 36,400 in 1978 to 84,800 in 2001. This rate is expected to rise to 115, 000 in 2010.

The average time to complete construction of a national cemetery is 7 years. The report of a study conducted pursuant to the Millennium Act concluded that an additional 31 national cemeteries will be required to meet the burial option demand through 2020. Legislation is currently pending in this session that will authorize the establishment of 10 new national cemeteries in areas of the country facing a shortage of burial space. Together with the 6 national cemeteries under development, this will go a long way toward fulfilling this need. NCA will be able to keep pace with current demand for burial space if this legislation is enacted and fully funded this year.

The American Legion urges Congress to provide sufficient major construction appropriations to permit NCA to accomplish its mandate of ensuring that burial in a national cemetery is a realistic option for 90 percent of our nations veterans.

NATIONAL SHRINE COMMITMENT

Maintaining cemeteries as National Shrines is one of NCA's top priorities. This commitment involves raising, realigning and cleaning headstones and markers to renovate gravesites. The work that has been done so far has been outstanding; however, adequate funding is key to maintaining this very important commitment. At the rate that Congress is funding this work, it will take 28 years to complete. The American Legion supports the goal of completing the NCA's National Shrine Commitment in five years. This Commitment includes the establishment of standards of appearance for national cemeteries that are equal to the standards of the finest cemeteries in the world. Operations, maintenance and renovation funding must be increased to reflect the true requirements of the National Cemetery Administration to fulfill this Commitment.

The American Legion recommends $274 Million for the National Cemetery Administration in FY 2006.

STATE CEMETERY GRANTS PROGRAM

The National Cemetery Administration (NCA) administers a program of grants to states to assist them in establishing or improving state-operated veterans cemeteries through VA's State Cemetery Grants Program (SCGP). Established in 1978, the matched-funds program helps to provide additional burial space for veterans in locations where there are no nearby national cemeteries. Through FY 2002, more than $169 million in grants have been awarded to states and the Territories of Guam and the Northern Marianas, including 5 new state cemeteries and the improvement and/or expansion of 9 existing ones.

Under the Veterans Programs Enhancement Act of 1998, P.L. 105-261, VA may now provide up to 100 percent of the development cost for an approved project. For establishment of new cemeteries, VA can provide for operating equipment. States are solely responsible for the acquisition of the necessary land.

The American Legion recommends $42 Million for the State Cemetery Grants Program in FY 2006.

VETERANS BENEFITS ADMINISTRATION

The Department of Veterans Affairs has a statutory responsibility to ensure the welfare of the nation's veterans, their families, and survivors. Each year, the 58 regional offices of the Veterans Benefits Administration (VBA) receive over 100,000 new and reopened benefits claims. A majority of these claims involve multiple issues that are legally and medically complex and time consuming to adjudicate. Whether a case is complex or simple, these offices are expected to develop and adjudicate veterans' and survivors' claims in a fair, legally proper, and timely manner.

CLAIMS BACKLOG

Last year we expressed concern about the probable effect of a major cut back in regional office staffing slated for FY 2004 and a further smaller reduction proposed for FY 2005. It did not appear that the available staffing resources were going to be sufficient to handle the additional workload associated with legislation enacted by this Congress affording new benefit entitlements, along with liberalized VA policy on diseases related to Agent Orange and required support for DOD's Combat Related Special Compensation Program (CRSC). There has also been an influx of new claims for service connection, due to the fact that enrollment in VA's medical care system remains closed to some Category 8 disabled veterans. Much of the overall increased workload, however, stems directly from the required rework of tens of thousands of pending and previously decided cases, due to precedent decisions of both the United States Court of Appeals for Veterans Claims and the United States Court of Appeals for the Federal Circuit.

The Veterans' Claims Assistance Act of 2000 (VCAA), P.L. 106-475, was designed to overcome deficiencies in the claims adjudication process, improve the way VBA communicates with claimants, and the way in which claims were developed. The basic goal was to ensure that VA regional offices provided individuals essential information concerning their claim, so that they would know what evidence they were expected to submit and what evidence VA would try and obtain. This legislation was expected to result in claims that were more fully developed and which could be adjudicated in a more expeditious and accurate manner. There was also an expectation that these improvements would increase claimant's satisfaction with the decision received and reduce the appeals workload for the Decision Review Officers and the Board of Veterans Appeals.

VBA has, over the last three years, begun aligning its policies and procedures to conform to the letter and intent of VCAA, and has directed most of the regional offices' time and effort toward reducing claims processing time and reducing the backlog of pending claims. Achievement of former Secretary Principi's stated goal of 100 days to process a claim, on average, and a backlog of 250,000 pending claims by the end of fiscal year 2003 has been and continues to be VBA's number one priority. To fulfill mandated production quotas, regional office management and adjudicators have been put in the difficult and unenviable position of having to choose between deciding thousands of cases as quickly as possible or going through the more time consuming steps necessary to comply with VCAA and provide the claimant full due process.

In October 2003, Former Secretary Principi announced that the claims backlog had been reduced to the promised target level. Claims processing times were also trending down toward the 100-day goal and the error rate was improving. From VBA's perspective, these results showed that

regional office service had improved dramatically. Part of Secretary Principi's promise was, once the backlog goal had been achieved, VBA would be able to shift time and attention to improving the quality of claims adjudication. However, experience has once again shown that "faster is not always better."

Unfortunately for thousands of veterans and their families, their rights under the VCAA have been subordinated to bureaucratic convenience for the sake of an arbitrary administrative goal. This persistent disregard of the law prompted thousands to file otherwise unnecessary appeals. Since judicial review of veterans' claims was enacted in 1988, of those cases appealed to the United States Court of Appeals for Veterans Claims (CAVC), the remand rate, historically, has been about fifty percent. In a series of precedent setting decisions by the CAVC and the United States Court of Appeals for the Federal Circuit, the courts have invalidated a number of longstanding VA policies and regulations because they were not consistent with the statute. In response to the these decisions, VBA provided the regional offices with revised templates for VCAA notices to conform to the directives of the court. Unfortunately, VA's notices still do not adequately fulfill the notice requirements of the VCAA.

These court decisions immediately added thousands of cases to regional office pending workloads, since they require the review and reworking of tens of thousands of completed and pending claims. Between October 2003 and December 2003, the case backlog increased from 250,000 to 350,000. From January to August 2004, the number of pending claims has been reduced only by some 25,000 cases. However, over the same period, the number of appeals pending in the regional offices has grown by 20,000 cases. Data on regional office performance appear to contradict VBA's description of improvements in service to veterans.

LACK OF QUALITY DECISION MAKING IN VBA

The adequacy of regional office staffing has as much to do with the actual number of personnel as it does with the level of training and competency of the adjudication staff. VA's FY 2005 budget request noted the fact that VBA has lost much of its institutional knowledge base over the past four years, due to the retirement of many of its 30-plus year employees. Retirements among this group are expected to continue at a significant rate in 2005. As a result, staffing at most regional offices is now made up mostly of trainees, with less than five years of experience. Over this same period, as regional office workload demands escalated, these trainees have been put into production units as soon as they completed their basic training.

The American Legion's visits to regional offices have found that, frequently, there have been too few supervisors or inexperienced supervisors to provide trainees necessary mentoring, training, and quality assurance. In addition, at many stations, ongoing training for the new hires as well as the more experienced staff would be postponed or suspended, so as to focus maximum effort on production. Despite the fact that VBA's policy of "production first" has resulted in many more veterans getting faster action on their claims, the downside has been that tens of thousands of cases have been prematurely and arbitrarily denied. As a consequence, the appeals burden at the regional offices, the Board and the Appeals Management Center (AMC) continues to grow. What must also be kept in mind is that there is a disabled veteran, most often with a family, behind each one of these appeals, who has been fighting the VA system for a year, two years, or more to get what he or she feels they are rightfully entitled to.

The American Legion was very disturbed by information presented at the July 2004 VBA Leadership Conference about regional office adjudicators' job performance. VBA had two groups of Veterans Service Representatives (VSRs) take a job skill certification test. There were 650 individuals tested. They were GS 10 and GS 11 with three to five years of regional office claims experience and were considered to be proficient workers. It was, therefore, very disconcerting to learn that only 25 percent of the GS 10s and 29 percent of the GS 11s passed the open book test. If these individuals are supposed to be VBA's best and brightest adjudicators, it is little wonder that appeal workload continues to rise, the combined overturn rate at the Board of Veterans' Appeals continues to be extremely high. From these results, it appears that, despite having spent millions on its adjudicator-training program, this effort has not succeeded in correcting the many problems that contribute to poor quality decision-making and create unnecessary appellate work. Rather than providing a solution to the problem, the deficiencies in training and the lack of effective quality assurance continue to fuel the growing backlogs.

APPEALS MANAGEMENT CENTER

As a result of a successful legal challenge to the establishment of a unit at the Board of Veterans' Appeals (Board or BVA) to undertake needed development of appeal cases, VBA established the AMC. Its purpose is to provide more expeditious action on remands and also to relieve the regional offices of the workload burden associated with remands. The AMC basically functions as a national regional office for this type of case. It undertakes the additional development of evidence specified by the Board and readjudicates the claim. With a staff of 82 FTEs the AMC is overwhelmed by a growing volume of cases. Initially, 16,484 cases were inherited from the now-defunct BVA development unit and, currently, the AMC has a total of 22,002 remands under development. As a result, VBA recently established AMC resource centers in St. Petersburg, Cleveland, and Huntington to assist with its enormous backlog. Although it is too early to comment on the productivity or quality of work produced by these resource centers, questions remain as to the AMC 's overall ability to produce quality and timely work in the face of the continually increasing backlog and the growing pressure to reduce it.

While the AMC is an admirable attempt by VBA to improve service to veterans, it does nothing to address the problems underlying the continued rise in the number of appeals and remands by the Board of Veterans Appeals. In our view, the very necessity of the AMC's existence begs the question – why hasn't VBA mandated the regional offices to correct their own mistakes?

This new super regional office is now responsible for correcting errors that the regional offices were unwilling or unable to do. However, the AMC has no authority to prevent the same type of error, which prompted the appeal and remand, from occurring again. It is worth noting that regional offices did not receive any work credit for remand actions. This should have been an incentive for local management to try and improve decision-making and avoid appeals and potential remands. Experience has shown just the opposite.

Since production work on new claims were the highest priority and there was no work credit for remands, many regional offices simply ignored their appellate workload with remands pending for two and three years. Now, there is still no clear incentive for the regional offices to improve quality. They are continuing to forward new cases to the Board where almost sixty percent are being remanded to the AMC. VBA must ensure that the regional offices are held accountable for

the poor quality of initial decision-making and development of appeals and not allow them to shift the workload onto the Board of Veterans Appeals and, ultimately, the AMC.

BOARD OF VETERANS' APPEALS

The BVA is a separate entity within VA. Its responsibility is to render a final decision on the propriety of a regional office decision. If the Board determines a final decision cannot be made on a case due to inadequate or incomplete development, including lack of due process, it has the authority to remand the case back to agency of original jurisdiction, which now includes the AMC, for additional required development and readjudication.

Regional office appeals and dispositions by the Board are a direct reflection of the level of claimant satisfaction or dissatisfaction with and confidence or lack thereof in the fairness and propriety of regional office adjudication. It is, therefore, painfully obvious that the level of dissatisfaction is substantial and growing, in view of the increasing number of new appeals coming into the system.

To ensure VA and VBA are meeting their responsibilities; The American Legion strongly believes that Congress must scrutinize VBA's budget requests more closely. Given current and projected future workload demands, regional offices clearly will need more rather than fewer personnel and The American Legion is ready to support additional staffing. However, VBA must be required to provide better justification for the resources it says are needed to carry out its mission and, in particular, how it intends to improve the level of adjudicator training, job competency, and quality assurance.

Mr. Chairman, this concludes my testimony. I again thank the Committee for this opportunity to express the views of The American Legion on VA's FY 2006 Budget Request and look forward to working with you and the Members of the Committee to ensure VA is funded at a level that will allow all veterans to receive the care they have earned through their service.